IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
KARL B. KURTZ – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 7296

August 17, 2006

Janet Walker-Anderson, Administrator
Portneuf Nephrology Center
2001 Bench Road
Pocatello, ID 83201

FILE COPY

RE: Portneuf Nephrology Center, provider #132506

Dear Ms. Walker-Anderson:

Based on the survey completed at Portneuf Nephrology Center on August 3, 2006 by our staff, we have determined that Portneuf Nephrology Center is out of compliance with the Medicare ESRD Conditions of Participation on Governing Body and Management (42 CFR 405.2116), Patient Long Term Program And Patient Care Plan (42 CFR 405.2137 and Minimal Service Requirements (42 CFR 405.2163. To participate as a provider of services in the Medicare Program, an ESRD must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused this condition to be unmet, substantially limit the capacity of Portneuf Nephrology Center to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before **September 18, 2006. To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than September 8, 2006.**

A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.
- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and
- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

Sylvia Creswell

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

GG/mlw

Enclosures

DaVita™

Gate City Dialysis

September 6, 2006

Gary Guiles, RN
Health Facility Surveyor
Bureau of Facility Standards
PO Box 83720
Boise, Id 83720-0036

RECEIVED
SEP - 7 2006
FACILITY STANDARDS

Dear Gary Guiles:

I have enclosed our Plan of Correction in regard to the survey you conducted at Gate City Dialysis on 07/31/06 through 8/03/06. I would like to invite you to revisit at any time to verify that compliancy has been achieved.

Thank-you for your help and assistance during this time.

Sincerely,

Janet Walker-Anderson

Janet Walker-Anderson, Facility Administrator
Gate City Dialysis
2001 Bench Road
Pocatello, Id. 83201

9-8-06 6:45 PM. I spoke with Janet Walker-Anderson by telephone. She stated to change all of the completion dates to 9-12-06 in order that we would have time to conduct a follow up survey prior to the 45th day.

(Gary Guiles) RN, HFS

RECEIVED

SEP - 7 2006

FACILITY STANDARDS

PRINTED: 08/17/2006
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152506	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	7001 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 000	INITIAL COMMENTS The following deficiencies were cited during the complaint and recertification survey of your facility. The surveyor conducting the review was Gary Gulles, RN, HFS. Acronyms used in this report include: CEO = Chief Executive Officer ESRD = End Stage Renal Disease H&P = History and Physical Examination LPN = Licensed Practical Nurse MSW = Medical Social Worker PCP = Patient Care Plan PEG tube = Percutaneous Endoscopic Gastrostomy tube	V 000	The Governing Body has reviewed the Statement of Deficiencies and has formed a comprehensive action plan to ensure Davita Policy and Procedures are followed and deficiencies are corrected. The Governing Body will review progress of the plan and ensure implementation.	
V 110	405.2136 GOVERNING BODY AND MANAGEMENT The ESRD facility is under the control of an identifiable governing body, or designated person(s) so functioning, with full legal authority and responsibility for the governance and operation of the facility. This CONDITION is not met as evidenced by: Based on review of clinical records and facility policies and occurrence reports, and patient and staff interview, and observation, it was determined the governing body failed to assume responsibility for the governance and operation of the facility. The governing body failed to appoint an administrator who assumed responsibility for the overall management of the facility (V129); failed to adopt comprehensive policies for the provision of social services and development of plans of care (V142); and failed to assume responsibility for maintaining and implementing	V 110	V110 GOVERNING BODY AND MANAGEMENT The Governing Body has determined that many of the problems cited in this report are due to difficulties with transition of medical records associated with a recent change of ownership. Gate City Dialysis was a newly acquired clinic by Davita in April, 2006. Prior patient information has not been available for dietitian and social worker notes, but has been requested from the previous management of the facility. Charts are in the process of being re-constructed as needed. Refer also to V129. (V110 continued nn page 2)	9-17-06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

9/6/06 Janet Walker-Anderson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132506	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	2801 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 110	Continued From page 1 written personnel policies and procedures that ensured reports of incidents and accidents were reviewed to identify health and safety hazards V146). In addition, the governing body failed to ensure patient care plans were developed, resulting in a finding of non-compliance with the Condition of Participation: Long Term Program and Care Plan (V186). The governing body also failed to ensure social services were provided to patients, resulting in a finding of non-compliance with the Condition of Participation: Minimal Service Requirements (V440).	V 110	(V110 continued from page 1) Care plans will include an attached sheet for progress notes that will more specifically address patient's needs, including social service needs. Refer also to V142. Late entries have been completed for both incidents as well as AORs. All necessary testing of involved patients has been completed to ensure the safety of all patients concerned. Quality Committee has reviewed the incidents, and this will be done on an on-going basis. Any identified learning needs will be addressed. Refer also to V146. The CSS audited all patient charts. All Care Plans and Long-term Care Plans will be brought current. A tracking tool will be utilized to ensure all are completed timely. Social assessments are now current. Refer also to V186 and V440. FA will be responsible. V129 - Please refer to page 3	9-17-06
V 129	405.2138(c) CHIEF EXECUTIVE OFFICER The governing body appoints a qualified chief executive officer who as the ESRD facility's administrator is responsible for the overall management of the facility; enforces the rules and regulations relative to the level of health care and safety of patients, and to the protection of their personal and property rights; and plans, organizes, and directs these responsibilities delegated to him by the governing body. This STANDARD is not met as evidenced by: Based on review of clinical records, facility policies, and occurrence reports, and staff interview and patient interviews, and observation, it was determined the governing body and the ESRD facility's administrator failed to assume responsibility for the overall management of the facility. The findings include: 1. The governing body and the administrator	V 129		

9/16/06 Janet Walker-Anderson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132566	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PONTNEUF NEPHROLOGY CENTER, LL	2091 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 129	Continued From page 2 failed to maintain and implement written personnel policies for the provision of social services and the development of plans of care. Refer to V142 as it relates to the lack of direction to staff regarding social services and plans of care. 2. The governing body and the administrator failed to develop policies and procedures to investigate significant incidents. Refer to V148 as it relates to the lack of a systematic process to investigate significant events in order to prevent future occurrences. 3. The governing body and the administrator failed to ensure PCPs were based on an assessment of patients' needs. Refer to V192 as it relates to the lack of comprehensive assessment of patient needs. 4. The governing body and the administrator failed to ensure PCPs were individualized and reflected patient needs. Refer to V193 as it relates to the lack of personalized PCPs to address individual patient needs. 5. The governing body and the administrator failed to ensure staff ratios met patient needs. Refer to V433 as it relates to the lack of sufficient staff to meet patient needs. 6. The governing body and the administrator failed to ensure social services were provided to patients and families. Refer to V445 as it relates to the lack of social services provided to patients. 7. The governing body and the administrator failed to ensure social services were provided	V 129	V129 CHIEF EXECUTIVE OFFICER 1. Patient charts have been requested from previous management. Social worker has brought psychosocial assessments current with the use of current care plans and progress notes. Care plans will be patient specific including addressing social functioning and adjustment. Charts will be audited at 10% monthly for thorough documentation. The CSS will be available in the clinic for education and support beginning the 29th of August through September 8. Refer also to V445 and v447. 2. Staff was in-serviced on August 29 regarding policies and procedures relating to adverse occurrences. Adverse occurrences will be reviewed through the QI process at Quality Committee meetings. Staff was instructed on complete and timely documentation. Staff was also in-serviced regarding preparing access sites for treatment such as taping securely and ensuring access sites are uncovered during treatment. FA will report to CQI monthly. FA will monitor by random observation. Refer also to V146. (V129 cont. on page 4)	9-17-06

9/6/06 Janet Walker-Anderson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132598	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	2081 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 129	Continued From page 3 based on an assessment of psychosocial needs. Refer to V447 as it relates to the lack of psychosocial assessments.	V 129	(V129 continued from page 3) 3. Patient needs will be addressed specifically in care plans and will address psychosocial needs and family social needs. Social worker has completed current psychosocial assessments with the use of current care plans and progress notes. Care plans will be patient specific including addressing social functioning and adjustment. Refer also to V192. 4. Patient charts have been requested from previous management. Care plans will be patient specific including addressing social functioning and adjustment. Psychosocial assessments have been brought current. The CSS will be available for assistance and support beginning the 29th of August through September 8. Refer also to V193. 5. Staffing ratios have been adjusted. Staffing is planned to address patient needs and to reflect company standards. Because of the recent change in ownership, teammates have been learning new procedures and new machines since April, 2006. absent. Refer also to V433. (V129 continued on page 5))	
V 142	405.1336(d) PERSONNEL P/P: GOOD CARE The governing body, through the chief executive officer of the ESRD facility, is responsible for maintaining and implementing written personnel policies and procedures that support sound patient care. This STANDARD is not met as evidenced by: The governing body and the CEO (administrator) of the ESRD facility failed to maintain and implement written personnel policies and procedures that supported sound patient care. The governing body and the CEO failed to adopt comprehensive policies for the provision of social services and development of plans of care. This resulted in the inability of the facility to provide social services and develop complete PCPs. The findings include: 1. The policy "Provision of Social Services", dated 1/2/02, stated social services would be provided and said "The amount of time the Social Worker spends in the facility will be dictated by the needs of the patient." The policy stated a psycho-social evaluation would be completed within 60 days but did not outline what items the evaluation should include. The policy also said the MSW would participate in the development of care plans for all patients but did not state how this was to occur since the care planning document did not contain a section for social service plans. The policy stated the MSW would write a progress note on	V 142		

9/6/06 Janet Walker-Anderson

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	132506	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	2001 BENCH ROAD POCATELLO, ID 83201

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V 142	Continued From page 4 at least a quarterly basis, but did not state how often, at a minimum, patients would be seen. The half page policy was the only policy directing the care of social services. This was confirmed by the administrator on 8/8/06 at 2 PM. Social services were not being provided to patients in a systematic manner. (Refer to V445 and V447 as they relate to the lack of psychosocial assessments, plans, and services.) The policy did not provide sufficient direction to staff to provide social services. 2. The policy "Development of Patient Care Plans and Long Term Programs", revised July 2004, stated PCPs would be developed and then reviewed at least every 6 months. The policy did not state what information the PCPs should contain. The form "Patient Care Plan-Progress Note", used for all patients, contained sections with information related to anemia, osteodystrophy, nutrition, laboratory values, dialysis adequacy, co-morbidities, cardiovascular status, functional status, and medications. The plan was preprinted with information such as laboratory values, medications, weights, etc., by the computer. Boxes were present to fill in or check, such as whether the blood pressure was stable or not and whether or not the patient had gained weight. Except for a few lines under the nutrition section, the plans did not contain space to write in the special needs of individual patients in relation to their care or how staff would address those needs. No section was available identifying and addressing psycho-social needs. The plans were not flexible enough to identify and address patient specific needs.	V 142	(V129 continued from page 4) 6. The Governing Body and FA are aware of their responsibilities to this facility and the patients. All charts have been audited for those lacking in psychosocial assessment and, progress notes. These areas have now have been brought current. Care plans will be patient specific including addressing social functioning and adjustment and will remain current utilizing a spreadsheet as a tracking tool. Refer also to V445. 7. Patient charts have been requested from previous management. Social worker has brought psychosocial assessments current with the use of current care plans and progress notes. Care plans will be patient specific including addressing social functioning and adjustment. The CSS will be available for assistance and support beginning the 29th of August through September 8. Refer also to V447. FA will be responsible.	9-17-06

9/6/06 Janet Walker-Anderson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	132506	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	2007 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 142	Continued From page 6 PCPs were not personalized for individual patients and did not reflect psychological, social, and functional needs. (Refer to V193 as it relates to the lack of comprehensive PCPs.) The policy did not provide sufficient direction to staff to develop complete PCPs.	V 142	V142 PERSONNEL P/P: GOOD CARE 1. Policies and Procedures for care plans are in place. Patient information prior to the April, 2006 acquisition has not been available for dietitian and social worker notes but has been requested from the previous management of the facility. Charts are in the process of being re-constructed. Social worker has brought psychosocial assessments current with the use of current care plans and progress notes. An additional progress note page will be added to charts for better patient specific care. A checklist was utilized as an audit tool. Care plans will be patient specific including addressing social functioning and adjustment. A Case coordinator also meets with each patient individually on a monthly basis regarding their care plan, including specific patient needs. The CSS will be available in the clinic for assistance and support beginning the 29th of August through September 8. Patient charts will be audited monthly at 10% to ensure all remain current for care plans. Refer also to V445 and V447. (V142 continued on page 7)	9-17-06
V 148	405.2139(d)(2) PERSONNEL P/P: INCIDENTS REVIEWED The governing body, through the chief executive officer of the ESRD facility, is responsible for maintaining and implementing written personnel policies and procedures that ensure that reports of incidents and accidents to patients and personnel are reviewed to identify health and safety hazards. This STANDARD is not met as evidenced by: Based on review of clinical records, facility policies, and occurrence reports, and staff interview, the governing body failed to assume responsibility for maintaining and implementing written personnel policies and procedures to ensure that reports of incidents and accidents to patients and personnel were reviewed in order to identify health and safety hazards. Two of two significant incidents that were documented in the preceding quarter had not been investigated to determine their causes and suggest ways to prevent future incidents. The findings include: 1. Two significant incidents were noted as having occurred in the past quarter prior to survey. These included: • patient #1 was a 61 year old male with a	V 148		

9/6/06 James Walker-Anderson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132596	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	2901 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 146	Continued From page 8 diagnosis of ESRD. He began dialysis at the facility on 11/8/05. A late entry by the LPN, dated 8/1/06, stated Patient #1 had received dialysis via another patient's reused dialyzer on 7/27/06. The treatment was stopped. The blood in the dialyzer and tubing was not returned. The correct dialyzer was then placed on another machine and dialysis continued. * Patient #5 was a 69 year old male with a diagnosis of ESRD. He began dialysis at the facility on 2/3/06. A run sheet, dated 6/23/06, stated a needle became dislodged while the patient was receiving dialysis resulting in a 600 milliliter blood loss. Occurrence reports were reviewed. An occurrence report had been completed for the incident involving Patient #5 but not for the other incident. Documentation was not present that either incident had been investigated by the facility in order to determine their causes and prevent further incidents from occurring. This was confirmed by the Administrator on 8/2/06 at 3:20 PM. She stated the incidents had not been investigated. 2. The policy, "ADVERSE OCCURRENCE REPORTING POLICY (NON-TEAMMATE RELATED)", revised July 2004, stated "1. Any unexpected event that is inconsistent with the...routine provision of of acute dialysis..." should be reported on a specific form. The policy stated "4. After completion of the (form), the Administrator/designee or manager will review the form for completeness and legibility." Except for incidents involving "unexpected deaths,	V 146	(V142 continued from page 6) 2. Care plans will include an attached sheet for progress notes that will more specifically address patient's needs. A Case Coordinator also meets with each patient individually on a monthly basis regarding their care plan, including specific patient needs. The CSS will be available in the clinic for assistance and support beginning the 29th of August through September 8. Patient charts will be audited monthly at 10% to ensure all remain current for care plans. Refer also to V193. FA to be responsible. V146 PERSONNEL P/P: INCIDENTS REVIEWED Staff was in-serviced on August 29 regarding policies and procedures relating to adverse occurrences and timely documentation. Staff was also in-serviced regarding preparing access sites for treatment such as taping adequately and ensuring access sites are uncovered during treatment. Late entries have been completed for both incidents and AOR forms. (V146 continued on page 8)	9-17-06 9-17-06

9/6/06 Janet Walker-Anderson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132806	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	2081 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 146	Continued From page 7 unexpected hospitalizations, and/or sentinel events", the policy did not require an investigation. The Administrator was interviewed on 8/2/06 at 3:20 PM. She stated did not know what the corporation expected in relation to the investigation of incidents.	V 146	(V146 continued from page 7) The Quality Committee will review adverse occurrences at the Quality meeting or more frequently as needed. All necessary testing of patients involved has been completed to ensure their safety. FA will report to CQI monthly.	9-17-06
V 185	405.2137 LONG-TERM PROGRAM & CARE PLAN Each facility maintains for each patient a written long-term program and a written patient care plan to ensure that each patient receives the appropriate modality of care and the appropriate care within that modality. The patient, or where appropriate, parent or legal guardian is involved with the health team in the planning of care. This CONDITION is not met as evidenced by: Based on review of clinical records and facility policies, and patient and staff interview, it was determined the dialysis facility failed to develop patient care plans to ensure that each patient received appropriate care. The facility failed to ensure patient care plans were based on an assessment of patients' needs including a psychosocial assessment (V192); and failed to ensure PCPs were personalized for individual patients, reflecting the psychological, social, and functional needs of patients (V193). The cumulative effect of these systemic practices resulted in the inability of the facility to meet patient needs as defined by a comprehensive PCP.	V 185	V185 LONG-TERM PROGRAM AND CARE PLAN CSS audited patient charts for long-term and care plans and all will be brought current. Psychosocial assessments were brought current utilizing a checklist as an auditing tool. An additional note page was added for progress notes to better address patient specific needs including social and functional needs. Administrative Assistant will audit charts at 10% monthly to ensure all remain current. FA will report to CQI monthly. Refer also to V192 and V193. FA will be responsible.	9-17-06

9/6/06 Janet Walker Anderson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132508	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	2001 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 192	405.2137(b) PATIENT CARE PLAN: WRITTEN, ASSESSMENT BASED There is a written patient care plan for each patient of an ESRD facility (including home dialysis patients under the supervision of the ESRD facility; see §405.2163(a)), based upon the nature of the patient's illness, the treatment prescribed, and an assessment of the patient's needs. This STANDARD is not met as evidenced by: Based on review of clinical records and staff interview, it was determined the facility failed to ensure patient care plans for 8 of 9 patients (#s 2-9) were based on an assessment of patients' needs including a psychosocial assessment. This resulted in a lack of social service plans for these patients. The findings include: 1. PCPs were not complete and did not reflect the psychological and social needs of 8 of 9 sampled patients (#s 2-9). Examples include: * Patient #2 was a 61 year old male with a diagnoses of ESRD. He began dialyzing at the facility in October 2005. A psychosocial assessment had not been completed for this patient and the PCP, dated 7/18/06, did not include a plan for social services. * Patient #3 was a 53 year old male with diagnoses of ESRD, diabetes, and schizophrenia. He began dialyzing at the facility in November 2002. He lived in a nursing home due to a psychiatric disability. When observed in the dialysis facility on 8/1/06 at 11:30 AM, the patient	V 192	V192 PATIENT CARE PLAN WRITTEN, ASSESSMENT BASED Care plans will include an attached sheet for progress notes that will more specifically address patient's needs. The facility currently has a Case Coordinator for each patient, who meets with each patient individually on a monthly basis regarding their care plan. All charts have been audited for those lacking in psychosocial assessments and have been brought current. Care plans will be patient specific including addressing social functioning and adjustment and will remain current utilizing a spreadsheet as a tracking tool. FA will be responsible.	9-17-06

9/6/06 Janee Walker-Anderson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137506	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	2001 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 192	Continued From page 9 was lying in a recliner with a blanket pulled over his head. He was moaning softly. A dialysis technician stated this was not unusual behavior for him. A psychosocial assessment had not been completed for this patient and the PCP, dated 7/18/06, did not include a plan for social services. * Patient #4 was a 36 year old female with diagnoses of ESRD, diabetes, and a history of myocardial infarction in 2003. She began peritoneal dialysis in July 2001. She had had at least 2 peritoneal infections in the past 6 months. She resided in a local prison and received peritoneal dialysis through Gate City Dialysis. A psychosocial assessment had not been completed for this patient and her PCP, dated 7/18/06, did not include a plan for social services. In addition, an assessment of the patient's living situation had not been completed in order to coordinate care with prison personnel to provide dialysis services. * Patient #5 was a 69 year old male with diagnoses of ESRD and diabetes. He had been dialyzing in the facility since 2/3/06. A psychosocial assessment had not been completed for this patient and the PCP, dated 7/17/06, did not include a plan for social services. * Patient #6 was a 71 year old female with diagnoses of ESRD, malnutrition with a PEG tube and schizoaffective disorder. She had been dialyzing in the facility since 6/23/06. She resided in a long term care facility at the state psychiatric hospital. The initial nursing assessment, dated 7/3/06, stated "Pt was very uncooperative to assessment. When asked questions, she would	V 192		

9/6/06 Janet Walker Anderson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	132608	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	2601 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 192	Continued From page 10 respond inappropriately, i.e.: they won't let me have potato chips because I am diabetic. When explaining reason for no potato chips, pt. became agitated. Pt just wanted to go home. 'You are just experimenting on me, there is nothing wrong.' Called (state hospital) and spoke with (RN) re: pt's hx." A psychosocial assessment had not been completed for this patient and the PCP, dated 7/18/06, did not include a plan for social services. * Patient #7 was a 39 year old male with diagnoses of ESRD and spina bifida. He had been dialyzing in the facility since 8/14/03. A hospital H&P on 1/17/06 stated the patient had been skipping dialysis sessions which led to increased weakness. A physician progress note, dated 8/5/06, stated the patient was complaining of headaches and the patient had missed dialysis a few times. The physician suspected the patient had uremic headaches. A psychosocial assessment had not been completed for this patient and the PCP, dated 7/17/06, did not include a plan for social services or a plan to address the patient's non-compliance with dialysis treatments. * Patient #8 was a 25 year old female with a diagnosis of ESRD. She began dialyzing at the facility in March 2006. Run sheets documented her dialysis treatments were terminated early 8 times in June 2006. Also, she had dialysis goals to remove 7 kilos of fluid during 7 treatments in the same month. A psychosocial assessment had not been completed for this patient and the PCP, dated 7/18/06, did not include a plan for social services.	V 192		

9/6/06 Janet Walker-Anderson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	132606	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	5001 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 192	Continued From page 11 * Patient #9 was a 52 year old female with diagnoses of ESRD, and ovarian cancer. She began dialyzing at the facility in February 2006. A note from a nurse practitioner at another facility on 6/30/06 stated the patient was to receive chemotherapy for her cancer. A psychosocial assessment had not been completed for this patient and the PCP, dated 7/18/06, did not include a plan for social services. 2. The administrator, interviewed on 8/2/06 at 3:20 PM, confirmed the missing plans and stated there was no place on the PCPs to address psychosocial needs.	V 192		
V 193	405.2137(b)(1) PATIENT CARE PLAN: INDIVIDUALIZED The patient care plan is personalized for the individual, reflects the psychological, social, and functional needs of the patient, and indicates the ESRD and other care required as well as the individualized modifications in approach necessary to achieve the long-term and short term goals. This STANDARD is not met as evidenced by: Based on review of clinical records and facility policies and staff interview, it was determined PCPs were not personalized for individual patients and did not reflect the psychological, social, and functional needs of 8 of 9 sampled patients (#s 2-9). The plans did not indicate the care required as well as the individualized modifications in approach needed for these patients. The findings include:	V 193	V193 PATIENT CARE PLAN: INDIVIDUALIZED Care plans will include an attached sheet for progress notes that will more specifically address patient's needs. A Case Coordinator also meets with each patient individually on a monthly basis regarding their care plan, including specific patient needs. The CSS will be available for assistance and support beginning the 29th of August through September 8. Patient charts will be audited monthly at 10% to ensure all remain current for care plans. FA will be responsible.	9-17-06

9/6/06 Janet Walker-Anderson

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132506	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	2001 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 193	Continued From page 12 1. Eight of nine PCPs were not complete and did not address patient specific issues which affected patients' dialysis treatments. Examples include: * Patient #2 was a 61 year old male with a diagnoses of ESRD. He began dialyzing at the facility in October 2005. A H&P from a local hospital, dated 6/6/06, stated he had shortness of breath and had been on oxygen for 6 years. His medical record stated he had been hospitalized on 6/5/06 for altered mental status and on 7/4/06 for pneumonia and possible pericardial disease. The use of oxygen as well as the two hospitalizations were not addressed on the PCP,dated 7/18/06. Nor were directions in place for staff to monitor the patient for these problems. * Patient #3 was a 53 year old male with diagnoses of ESRD, diabetes, and schizophrenia. He began dialyzing at the facility in November 2002. He lived in a nursing home due to his psychiatric disability. When observed in the dialysis facility on 8/1/06 at 11:30 AM, the patient was lying in a recliner with a blanket pulled over his head moaning softly. A dialysis technician stated this was not unusual behavior for him. Specific behaviors related to the patient's schizophrenia and directions to staff regarding these behaviors were not mentioned on his PCP, dated 7/18/06. * Patient #4 was a 38 year old female with diagnoses of ESRD, diabetes, and a history of myocardial infarction in 2003. She began peritoneal dialysis in July 2001. She resided in a local prison and received peritoneal dialysis through Gate City Dialysis. The patient was observed at the facility on the afternoon of 8/1/06.	V 193		

9/16/06 Janet Walker-Anderson

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132508	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	2001 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 193	Continued From page 13 She was in shackles and accompanied by two guards. The nurse who directed the home dialysis program was interviewed on 8/1/06 at 4:10 PM. She said she was not aware of the reason for the patient's incarceration. She said a high protein diet had been recommended for the patient but she was not sure the prison would provide this. The PCP, dated 7/18/06, did not mention the patient was in prison, did not define a liaison at the prison for staff to communicate with regarding the patient's care, and did not state what crime the patient had been convicted of and whether or not special measures needed to be taken to ensure the safety of patients and staff. * Patient #5 was a 60 year old male with diagnoses of ESRD and diabetes. He had been dialyzing in the facility since 2/3/05. His record stated that, on 8/23/05, his needle had become dislodged during a treatment and he had lost approximately 500 milliliters of blood. On 8/2/06 at 9 AM, a dialysis technician stated staff were now double taping the needles to prevent a recurrence of the bleeding. The PCP, dated 7/17/06, did not address taping the needles so they would not be dislodged. * Patient #6 was a 71 year old female with diagnoses of ESRD, malnutrition with a PEG tube and schizoaffective disorder. She had been dialyzing in the facility since 6/23/06. She resided in a long term care facility at the state psychiatric hospital. The initial nursing assessment, dated 7/3/06, stated "Pt was very uncooperative to assessment. When asked questions, she would respond inappropriately, i.e.: they won't let me have potato chips because I am diabetic. When explaining reason for no potato chips, pt. became	V 193		

9/6/06 Janet Walker-Anderson

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132506	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	2001 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 193	Continued From page 14 agitated. Pt just wanted to go home. 'You are just experimenting on me, there is nothing wrong.' Called (state hospital) and spoke with (RN) re: pt's hx." Patient #6's PCP did not address how staff should approach the patient in order to limit her agitation and paranoia. * Patient #7 was a 39 year old male with diagnoses of ESRD and spina bifida. He had been dialyzing in the facility since 9/14/03. A hospital H&P on 1/17/06 stated the patient had been skipping dialysis sessions which led to increased weakness. A physician progress note, dated 6/5/06, stated the patient was complaining of headaches and the patient had missed dialysis a few times. The physician suspected the patient had uremic headaches. The PCP, dated 7/17/06, did not address the non-compliance with dialysis treatments. * Patient #8 was a 25 year old female with a diagnosis of ESRD. She began dialyzing at the facility in March 2006. Run sheets documented her dialysis treatments were terminated early 6 times in June 2006. Also, her dialysis goal was to remove 7 kilos of fluid during 7 treatments in the same month. The PCP, dated 7/18/06, did not address the patient's early treatment termination or excessive fluid gain. * Patient #9 was a 52 year old female with diagnoses of ESRD, and ovarian cancer. She began dialyzing at the facility in February 2006. A note from a nurse practitioner at another facility on 6/30/06 stated the patient was to receive chemotherapy for her cancer. The PCP, dated 7/18/06, did not address the patient's cancer or chemotherapy in relation to her dialysis	V 193		

9-6-06 Janet Walker-Anderson

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132506	A. BUILDING _____ B. WING _____	08/03/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	3001 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 199	Continued From page 15 treatments. 2. The policy "Development of Patient Care Plans and Long Term Programs", revised July 2004, stated PCPs would be developed for all patients. The policy did not state what information the PCPs should contain. The form "Patient Care Plan-Progress Note", used for all patients, contained sections with information related to anemia, osteodystrophy, nutrition, laboratory values, dialysis adequacy, co-morbidities, cardiovascular status, functional status, and medications the patient was taking. The plan was preprinted with information such as laboratory values, medications, weights, etc., by the computer. Boxes were present to fill in or check, such as whether the blood pressure was stable or not and whether the patient had gained weight. Except for a few lines under the nutrition section, the plans did not contain space to write in special needs of individual patients in relation to their care or how staff would address those needs. No section was available identifying and addressing psycho-social needs. The plans were not flexible enough to identify and address patient specific needs. The administrator, interviewed on 8/2/08 at 3:20 PM, confirmed that, except for the preprinted items, there was no place on the PCPs to address patient specific nursing and other items.	V 199		

9/16/08 Janet Walker-Lindeen

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	132006	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	3901 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 433	405.2162(b)(2) STAFF RATIOS MEET PATIENT NEEDS Whenever patients are undergoing dialysis, an adequate number of personnel are present so that the patient/staff ratio is appropriate to the level of dialysis care being given and meets the needs of patients. This STANDARD is not met as evidenced by: Based on staff and patient interview and observation, it was determined the facility failed to ensure an adequate number of personnel were present to meet the needs of patients. The findings include: 1. Four patients and/or family members were interviewed during the survey on 8/1/06 and 8/2/06. Three of those patients complained their dialysis treatments were not started at the scheduled times. They said they had to wait up to 45 minutes after their assigned times for staff to start their dialysis. In addition, three of those patients interviewed, stated staff did not closely check test strips. Facility policy stated 2 staff were to check test strips for the absence of germicide in dialyzers prior to connecting patients to them. The three patients said one staff would hold up a test strip and another staff member across the room would glance at it without really checking the strip. They said staff were too busy to cross the room and look closely at the strips. 2. Several short observations were made between 11 AM and 2:30 PM on 8/2/06. During that period, 3 machines alarmed, lasting between 1 minute 18 seconds and 1 minute 56 seconds, before staff checked the patient and the machine. 3. The administrator was interviewed on 8/1/06 at	V 433	V433 STAFF RATIOS MEET PATIENT NEEDS The facility utilizes ratios staffing of at least 4-1. We believe that the observations made by patients and surveyors were due to teammates learning new procedures and the operation of machines to them. Teammate education is still ongoing. The CSS will provide additional educational support with new processes. A new staffing plan has been put in place to ensure consistent care and adequate staff ratios. Staff was in-serviced on August 5 regarding Safety Checks and prescription verifications. No patient will start treatment until 2 teammates have verified that prescription and safety checks are correct and complete. FA will audit flow sheets to ensure verifications and safety checks are being completed and documented. FA will complete random checks by observation regarding timely patient care. (V433 continued on page 18)	9-17-06

9/6/06 Janet Wilka-Anderson

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	132508	A. BUILDING _____ B. WING _____	08/03/2006

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PORTNEUF NEPHROLOGY CENTER, LL	2001 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 433	Continued From page 17 2:20 PM. She stated the staffing ratio under the previous owners had been 1 dialysis technician to 3 patients. Under the new owners, that ratio had decreased to 1 dialysis technician to 4 patients. In addition, she stated the facility had changed dialysis machines in the past month and it was taking longer to set up these machines. She said some patients had been late to start dialysis during this time. The administrator was observed working the floor at 11:30 AM on 8/2/06. She stated she tried to work the floor during this time, rather than attend to administrative duties, in an attempt to keep staff from falling behind during the change of patient shifts.	V 433	(V433 continued from page 17) The FA or designee will also observe to ensure teammates answer alarms in a timely manner and findings will be recorded on the monthly report. Teammates failing to perform in a satisfactory manner will be counseled. Staffing patterns will also be reviewed FA and CSS to determine appropriate times for breaks and lunch dependent on care needs. FA to be responsible.	9-17-06
V 440	405.2183 MINIMAL SERVICE REQUIREMENTS The facility must provide dialysis services as well as adequate laboratory, social, and dietetic services to meet the needs of the ESRD patient. This CONDITION is not met as evidenced by: Based on review of clinical records and facility policies, and patient and staff interview, it was determined the dialysis facility failed to provide social services to meet the needs of ESRD patients. The facility failed to ensure social services were provided to patients and their families (V445). The facility also failed to ensure a social worker conducted psychosocial evaluations (V447). The cumulative effect of these practices resulted in the facility's inability to provide social and psychological support to patients in a planned and systematic manner.	V 440	V440 MINIMAL SERVICE REQUIREMENTS Patient information prior to the April, 2006 acquisition has not been available for dietitian and social worker notes but has been requested from the previous management of the facility. Charts are in the process of being re-constructed. The Social Worker is present in this clinic full time and has in-depth knowledge of patients' needs and facility interventions. (V440 continued on page 19)	9-17-06

9/6/06 Janet Walker-Anderson

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	132506	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	1901 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 445	405.2163(c) SOCIAL SERVICES Social services are provided to patients and their families and are directed at supporting and maximizing the social functioning and adjustment of the patient. This STANDARD is not met as evidenced by: Based on review of clinical records and facility policies, and patient and staff interview, it was determined the dialysis facility failed to ensure social services were provided to patients and their families and were directed at supporting and maximizing the social functioning and adjustment of 8 of 9 sampled patients (#s 2-9). The findings include: 1. The facility failed to provided social services to 8 of 9 sampled patients (#s 2-9). Examples include: * Patient #2 was a 61 year old male with a diagnoses of ESRD. He began dialyzing at the facility in October 2005. Documentation of a psychosocial evaluation was not present in the patient's medical record. A note by the MSW, dated 6/5/06, stated the patient was confused and disoriented during a treatment. She had notified the patient's wife of his behavior. No other MSW notes were present. The MSW stated she did not have a documented evaluation or other documentation of MSW involvement when this information was requested requested on 8/2/06 at 10:15 AM. * Patient #3 was a 53 year old male with diagnoses of ESRD, diabetes, and schizophrenia. He began dialyzing at the facility in November 2002. He lived in a nursing home due to his psychiatric disability. When observed in the	V 445	(V440 continued from page 18) Social worker has brought psychosocial assessments current with the use of current care plans and progress notes. An additional progress note page will be added to charts for better specific patient care. A checklist was utilized as an audit tool. Care plans will be patient specific including addressing social functioning and adjustment. A Case coordinator also meets with each patient individually on a monthly basis regarding their care plan, including specific patient needs. The CSS will be available in the clinic for assistance and support beginning the 29th of August through September 8. Patient charts will be audited monthly at 10% to ensure all remain current for care plans. Refer also to V445 and V447. Fa to be responsible. (V445 - Please refer to page 20)	9-17-06

9/6/06 Janet Walker-Anderson

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V 445	Continued From page 19 dialysis facility on 8/1/06 at 11:30 AM, the patient was lying in a recliner with a blanket pulled over his head moaning softly. A dialysis technician stated this was not unusual behavior for him. Documentation of a psychosocial evaluation and other documentation of MSW involvement was not present in the patient's medical record. The MSW stated she did not have a documented evaluation or other documentation of MSW involvement when this information was requested on 8/2/06 at 10:15 AM. She also stated she had spoken frequently with the social worker at the nursing home where the patient resided but had not documented these conversations. * Patient #4 was a 38 year old female with diagnoses of ESRD, diabetes, and a history of myocardial infarction in 2003. She began peritoneal dialysis in July 2001. She resided in a local prison and received peritoneal dialysis through Gate City Dialysis. The patient was observed at the facility on the afternoon of 8/1/06. She was in shackles and accompanied by two guards. The nurse who directed the home dialysis program was interviewed on 8/1/06 at 4:10 PM. She said she was not aware of the reason for the patient's incarceration. She said a high protein diet had been recommended for the patient but she was not sure the prison would provide this. The PCP, dated 7/18/06, did not define a liaison at the prison for staff to communicate with regarding the patient's care, did not state what crime the patient had been convicted of, and whether or not special measures needed to be taken to ensure the safety of the patient and staff. Documentation of a psychosocial evaluation was not present in the patient's medical record. The only MSW note	V 445	V445 SOCIAL SERVICES It is believed that the root cause of this problem was related to discontinuity in medical records at the time of the April, 2006. Charts are in the process of being re-constructed. Social worker has brought psychosocial assessments current with the use of current care plans and progress notes. A psychosocial progress note page will be utilized for better documentation of Social Worker participation in care planning and in documenting patient specific care. Administrative Assistant will continue monthly chart audits of 10% to ensure social assessments, care plans and progress notes are current. Social Worker will be responsible.	9-17-06

9/12/06 Janet Walker-Anderson

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132506	A. BUILDING _____ B. WING _____	08/03/2006

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V 445	Continued From page 20	V 445		

present was dated 7/18/06. It stated the patient was in for a clinic visit and did not wish to speak to the MSW. The MSW stated she did not have a documented evaluation or other documentation of MSW involvement when this information was requested on 8/2/06 at 10:15 AM.

* Patient #5 was a 69 year old male with diagnoses of ESRD and diabetes. He had been dialyzing in the facility since 2/3/06. Documentation of a psychosocial evaluation was not present in the patient's medical record. The social worker was not able to provide the evaluation when this information was requested on 8/2/06 at 10:15 AM.

* Patient #9 was a 71 year old female with diagnoses of ESRD, malnutrition with a PEG tube and schizoaffective disorder. She had been dialyzing in the facility since 6/23/06. She resided in a long term care facility at the state psychiatric hospital. The initial nursing assessment, dated 7/3/06, stated "Pt was very uncooperative to assessment. When asked questions, she would respond inappropriately, i.e.: they won't let me have potato chips because I am diabetic. When explaining reason for no potato chips, pt. became agitated. Pt just wanted to go home. 'You are just experimenting on me, there is nothing wrong.' Called (state hospital) and spoke with (RN) re: pt's hx." Documentation of a psychosocial evaluation and other documentation of MSW involvement was not present in the patient's medical record. Patient #9's PCP did not address how staff should approach the patient in order to limit her agitation and paranoia. The MSW stated she did not have a documented evaluation or other documentation of MSW involvement when

9/6/06 Janet Walker-Anderson

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132636	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	2001 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 445	Continued From page 21 this information was requested on 8/2/06 at 10:16 AM. * Patient #7 was a 59 year old male with diagnoses of ESRD and spina bifida. He had been dialyzing in the facility since 8/14/03. A hospital H&P, dated 1/17/06, stated the patient had been skipping dialysis sessions which led to increased weakness. A physician progress note, dated 6/5/06, stated the patient was complaining of headaches and the patient had missed dialysis a few times. The physician suspected the patient had uremic headaches. The PCP, dated 7/17/06, did not address the missed dialysis treatments. Documentation of a psychosocial evaluation and other documentation of MSW involvement was not present in the patient's medical record. The MSW stated she did not have a documented evaluation or other documentation of MSW involvement when this information was requested on 8/2/06 at 10:15 AM. * Patient #8 was a 25 year old female with a diagnosis of ESRD. She began dialyzing at the facility in March 2006. Documentation of a psychosocial evaluation and other documentation of MSW involvement was not present in the patient's medical record. The MSW stated she did not have a documented evaluation or other documentation of MSW involvement when requested on 8/2/06 at 10:15 AM. * Patient #9 was a 52 year old female with diagnoses of ESRD, and ovarian cancer. She began dialyzing at the facility in February 2006. A note from a nurse practitioner at another facility on 6/30/06 stated the patient was to receive chemotherapy for her cancer.	V 445		

9/6/06 Janice Walker-Anderson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132506	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	2001 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 445	Continued From page 22 Documentation of a psychosocial evaluation and other documentation of MSW involvement was not present in the patient's medical record. The MSW stated she did not have a documented evaluation or other documentation of MSW involvement when this information was requested on 8/2/06 at 4:05 PM. 2. Four patients were interviewed on 8/1/06 and 8/2/06. Two of those patients stated they had not seen a social worker in the past 6 months and did not think a social worker currently worked at the facility. 3. The policy "Provision of Social Services", dated 1/2/02, stated social services would be provided and said "The amount of time the Social Worker spends in the facility will be dictated by the needs of the patient." The policy stated a psycho-social evaluation would be completed within 60 days. The policy also said the MSW would participate in the development of care plans for all patients. The policy stated the MSW would write a progress note at least quarterly. This policy had not been followed.	V 445		

9/6/06 Janet Walker-Andersen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132506	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	2001 BENCH ROAD POCATELLO, ID 83204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 447	405.2169(c) SOCIAL WORKER RESPONSIBILITIES The qualified social worker is responsible for conducting psychosocial evaluations, participating in team review of patient progress and recommending changes in treatment based on the patient's current psychosocial needs, providing casework and groupwork services to patients and their families in dealing with the special problems associated with ESRD, and identifying community social agencies and other resources and assisting patients and families to utilize them. This STANDARD is not met as evidenced by: Based on review of clinical records and facility policies and staff interview, it was determined the dialysis facility failed to ensure a social worker conducted psychosocial evaluations, for 8 of 9 sampled patients (#s 2-9). The findings include: 1. Eight of nine sampled patients (#s 2-9) did not have documented psychosocial evaluations. Examples include: * Patient #2 was a 61 year old male with a diagnosis of ESRD. He began dialyzing at the facility in October 2005. Documentation of a psychosocial evaluation was not present in the patient's medical record. The MSW stated she did not have a documented evaluation, when this information was requested on 8/2/06 at 10:15 AM. * Patient #3 was a 53 year old male with diagnoses of ESRD, diabetes, and schizophrenia. He began dialyzing at the facility in November 2002. He lived in a nursing home due to his psychiatric disability. Documentation of a psychosocial evaluation was not present in the	V 447	V447 SOCIAL WORKER RESPONSIBILITIES The Social Worker is present in this clinic full time and has in-depth knowledge of patients' needs and facility interventions. There was discontinuity in documentations associated with the April, 2006 acquisition. Prior Social Services documentation has been requested from the previous management of the facility. Charts are in the process of being re-constructed. Social worker has brought psychosocial assessments current with the use of current care plans and progress notes. An additional progress note page will be added to charts for better patient specific care. The Social Worker is part of the Quality Committee and will self-report on progress with maintaining current documentation to the Committee. Administrative Assistant will continue monthly chart audits of 10% to ensure social assessments, care plans and progress notes are current. Social Worker will be responsible.	9-17-06

9/6/06 Janet Walker - Andelson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	132506	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	2001 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 447	Continued From page 24 patient's medical record. The MSW stated she did not have a documented evaluation, when this information was requested on 8/2/06 at 10:15 AM. * Patient #4 was a 36 year old female with diagnoses of ESRD, diabetes, and a history of myocardial infarction in 2003. She began peritoneal dialysis in July 2001. She resided in a local prison and received peritoneal dialysis through Gate City Dialysis. Documentation of a psychosocial evaluation was not present in the patient's medical record. The MSW stated she did not have a documented evaluation, when this information was requested on 8/2/06 at 10:15 AM. * Patient #5 was a 69 year old male with diagnoses of ESRD and diabetes. He had been dialyzing in the facility since 2/3/06. Documentation of a psychosocial evaluation was not present in the patient's medical record. The MSW stated she did not have a documented evaluation, when this information was requested on 8/2/06 at 10:15 AM. * Patient #6 was a 71 year old female with diagnoses of ESRD, malnutrition with a PEG tube and schizoaffective disorder. She had been dialyzing in the facility since 6/28/06. She resided in a long term care facility at the state psychiatric hospital. Documentation of a psychosocial evaluation was not present in the patient's medical record. The MSW stated she did not have a documented evaluation, when this information was requested on 8/2/06 at 10:15 AM. * Patient #7 was a 39 year old male with diagnoses of ESRD and spina bifida. He had been dialyzing in the facility since 6/14/03.	V 447		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132506	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTNEUF NEPHROLOGY CENTER, LL	2001 BENCH ROAD POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 447	Continued From page 25 Documentation of a psychosocial evaluation and other documentation of MSW involvement was not present in the patient's medical record. The MSW stated she did not have a documented evaluation, when requested on 8/2/06 at 10:15 AM. * Patient #8 was a 28 year old female with a diagnosis of ESRD. She began dialyzing at the facility in March 2006. Documentation of a psychosocial evaluation was not present in the patient's medical record. The MSW stated she did not have a documented evaluation, when this information was requested on 8/2/06 at 10:15 AM. * Patient #9 was a 52 year old female with diagnoses of ESRD, and ovarian cancer. She began dialyzing at the facility in February 2006. Documentation of a psychosocial evaluation was not present in the patient's medical record. The MSW stated she did not have a documented evaluation, when this information was requested on 8/2/06 at 4:06 PM. The policy "Provision of Social Services", dated 1/2/02, stated a psycho-social evaluation would be completed within 60 days of a patient's admission. This policy had not been followed.	V 447		

9/6/06 Janet Walker-Anderson

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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August 21, 2006

Janet Walker-Anderson, Administrator
Portneuf Nephrology Center
2001 Bench Road
Pocatello, ID 83201

Dear Ms. Walker-Anderson:

On August 3, 2006, a complaint investigation survey was conducted at Portneuf Nephrology Center. The survey was conducted by Gary Guiles, Registered Nurse. This report outlines the findings of our investigation.

Complaint # ID00001692

Allegations #1: The patient was given the wrong dialyzer. He dialyzed for 20-30 minutes before the mistake was discovered.

Findings: An unannounced visit was made to the dialysis center on 7/31/06. A full Medicare recertification survey was conducted from 7/31/06 through 8/3/06.

In one record, a late entry by the LPN, stated a patient had received dialysis via another patient's reused dialyzer on 7/27/06. The treatment was stopped. The blood in the dialyzer and tubing was not returned. The correct dialyzer was then placed on another machine and dialysis continued.

The physician on call for 7/27/06 was interviewed on 8/1/06. He stated he had seen the affected patient on the day of the incident. He said he had ordered laboratory work and would continue to follow the patient at intervals to determine whether or not an injury had occurred as a result of the incident. The patient the incorrect dialyzer belonged to did not have a history of any blood borne infection or high risk behaviors.

The Reuse Technician involved in the incident was interviewed. The technician stated it had been a busy day when the dialyzers were reprocessed. A number of cleansed dialyzers had been allowed to pile up on the counter and two of the dialyzer labels had accidentally been transposed. The incident was discovered during dialysis when staff checked the labels on the second dialyzer and found they did not match. The technician said all of the dialyzers had been checked following the incident. At that time, the labeling was correct for the other dialyzers. Following the incident, the Reuse Technician stated the reprocessing procedure was changed and only one dialyzer was now being placed on the counter at a time. This dialyzer was to be labeled and put away before placing another dialyzer on the counter. This procedure was observed during the three days the surveyor was in the building. However, when interviewed, the administrator stated the procedure had not been formally changed. She also stated staff could place up to two dialyzers on the counter at a time while labeling them. All care staff had been directed to re-read the existing policies on reuse and setting up dialysis. A meeting with patient care staff had been held on the morning of 7/31/06 prior to the surveyor's arrival. The purpose of the meeting was to discuss the incident and instruct staff to re-read the policy.

A comprehensive account of the incident could not be established. For example, apparently only one of the dialyzers was mislabeled. If the account staff related to the surveyor was accurate, two of the dialyzers should have been mislabeled. Four staff who were involved in the incident were interviewed but they could not explain what happened to the missing label. In addition, there was no record of the contaminated dialyzer being disposed of. Staff were told to dispose of it but stated they had stored the dialyzer in a refrigerator with other dialyzers awaiting reprocessing. There was no record it had been reprocessed. Staff were unable to locate the dialyzer on the morning of 8/2/06. The most likely scenario was that the dialyzer had been disposed of but staff could not substantiate this.

An investigation of the above incident had not occurred and none was planned. The Administrator was interviewed on 8/2/06 at 3:20 PM. She confirmed a formal investigation had not occurred. She stated she did not know what the corporation expected in relation to the investigation of incidents.

During the survey, another adverse occurrence was noted. A run sheet, dated 6/23/06, stated a needle became dislodged while a patient was receiving dialysis, resulting in a 500 milliliter blood loss. Again, the facility had not investigated the incident. This was also confirmed by the Administrator.

The policy, "ADVERSE OCCURRENCE REPORTING POLICY (NON-TEAMMATE RELATED)", revised July 2004, stated "1. Any unexpected event that is inconsistent with the...routine provision of of acute dialysis..." should be reported on a specific form. The policy stated "4. After completion of the (form), the Administrator/designee or manager will review the form for completeness and legibility." Except for incidents involving "unexpected deaths, unexpected hospitalizations, and/or sentinel events", the policy did not require an investigation.

Conclusion: The allegation was substantiated. It was determined the Condition of Coverage: Governing Body and Management, at 42 CFR 405.2136, was not met, partly because no procedure was in place to ensure significant adverse events were investigated. The facility was placed on a 90 day termination track with the opportunity to correct the deficiencies.

Allegation #2: When staff cleanse patients' arms prior to cannulation, they don't cleanse the skin from the inside out. Instead, they rub the area all over in no particular pattern.

Findings: The policy "AV GRAFT OR FISTULA CANNULATION WITH SAFETY FISTULA NEEDLES", revised, March 2004, stated, "9. With clean gloved hands, cleanse the site by applying an antimicrobial agent or germicidal agent using a circular rubbing motion, center out."

Conclusion: On the morning of 8/2/06, three different staff members were observed cleansing patients' access sites prior to cannulation. All staff who were observed followed the policy and cleansed the sites from the center out. The complaint could not be substantiated.

Allegation #3: Dialysis treatments are not started on time. Patients arrive at their scheduled times and have to wait 30-45 minutes for staff to actually begin their dialysis.

Findings: Four patients and/or family members were interviewed during the survey on 8/1/06 and 8/2/06. Three of those patients complained their dialysis treatments were not started at the scheduled times. They said they had to wait up to 45 minutes after their assigned times for staff to start their dialysis. In addition, three of those patients interviewed stated staff did not closely check test strips. Facility policy stated 2 staff were to check test strips for the absence of germicide in dialyzers prior to connecting patients. The three patients said one staff would hold up a test strip and another staff member across the room would glance at it without really checking the strip. They said staff were too busy to cross the room and look closely at the strips.

Several short observations were made between 11 AM and 2:30 PM on 8/2/06. During that period, 3 machines alarmed, lasting between 1 minute 15 seconds and 1 minute 55 seconds, before staff checked the patient and the machine.

The administrator was interviewed on 8/1/06 at 2:20 PM. She stated the staffing ratio under the previous owners had been 1 dialysis technician to 3 patients. Under the new owners, that ratio had decreased to 1 dialysis technician to 4 patients. In addition, she stated the facility had changed dialysis machines in the past month and it was taking longer to set up these machines. She said some patients had been late to start dialysis during this time. The administrator was observed working the floor at 11:30 AM on 8/2/06. She stated she tried to work the floor during this time, rather than attend to administrative duties, in an attempt to keep staff from falling behind during the patient change of shifts.

Conclusion: The complaint was substantiated. A deficiency was cited at 42 CFR 405.2162 in relation to the lack of direct care staff.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208)334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

GARY GUILES, R.N.
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

GG/mlw